

Return Visit Patient Questionnaire

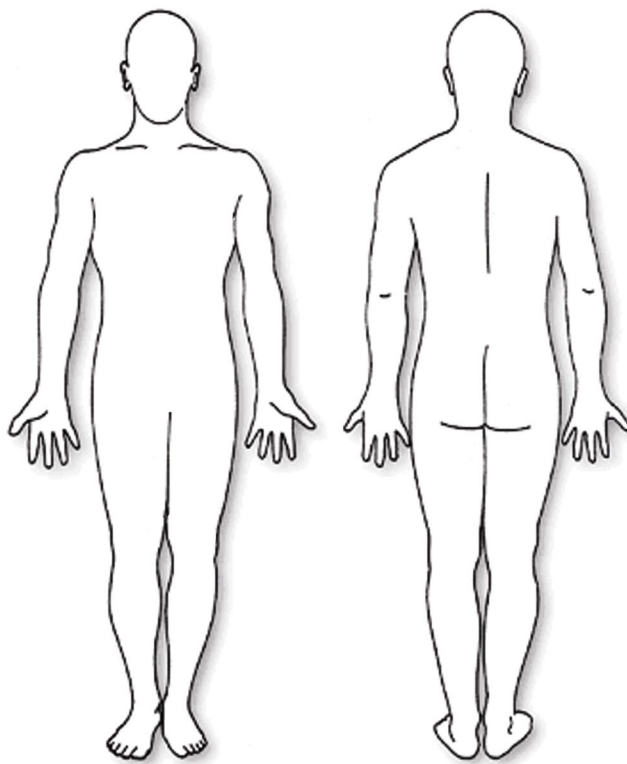
Name: _____

Address: _____

Phone #: _____

Date of Visit: _____

Please indicate on the diagram below where you feel pain. Mark **severe** locations with "O"s and use an "X" where it is the **worst**.



Has your pain affected your relationship with any of the following people?

- | | |
|--|--|
| <input type="checkbox"/> Spouse or Significant Other | <input type="checkbox"/> Close Friend(s) |
| <input type="checkbox"/> Children | <input type="checkbox"/> Employer |
| <input type="checkbox"/> Other Family Member(s) | |

How much time does the complaint cause you to miss work or prevent household chores?

_____ <25% _____ 25-50% _____ 50-75% _____ 75-100%

Rate your pain level from 0 to 10 with 10 being the worst pain imaginable by circling the number

What was your pain level on average during the past week? 0 1 2 3 4 5 6 7 8 9 10

What was your pain level at its worst during the past week? 0 1 2 3 4 5 6 7 8 9 10

Compared to your previous treatment with other pain medications, what percentage of your pain has been relieved? 0 1 2 3 4 5 6 7 8 9 10

Is your current level of pain relief sufficient to make a real difference in your life? 0 1 2 3 4 5 6 7 8 9 10

Please rate the following activities of daily living since having begun your current treatment plan for your pain. (check the appropriate box)

	Better	Same	Worse
Physical functioning			
Mood			
Family relationships			
Social relationships			
Sleep pattern			
Overall functioning			

Are you able to tolerate your current pain relievers? ____Yes ____No

Are you experiencing any side effects from your current pain relievers? ____Yes ____No

Rate the severity of constipation you are experiencing.

____None ____Mild ____Moderate ____Severe

Are the side effects tolerable? ____Yes ____No ____Unsure